Date **Initials**

PATIENT HEALTH RECORDS (*Please complete all pages/BLUE INK)*

DATE**_____**

Name_____Sex_____Marital Status_____

Address_____**DOB**_____

City_____State_____ZipCode_____

Home Phone ( )_____ Work ( )_____

Email address_____ Cell Phone ( )_____

SS#_____ Driver's License # _____

Employer_____Employer Address_____

Spouse's name_____SS#_____

D.O.B._____Employer_____

Parent's Name (if a minor)_____

I was referred to this office by _____

Dental Insurance Information

Insurance_____Insured_____

Address_____Phone_____

Medical Information

Physician's name_____Phone#_____

List the medications you are now taking on the last page of this packet

List any medications to which you are allergic_____

Have you had dental x-rays in the last 5 years? _____

When was your last dental exam? _____Dentist's name_____

Do you clinch or grind your teeth? _____

Have you ever had a blood transfusion_____Date_____

Have you been tested for Hepatitus? _____Results_____

Do you have a history of cold sores or fever blisters? _____

Are you being treated with immunosuppressive drugs? _____

Do you have or have you ever been informed that you had any of the following?

Aids	yes	no	Hypertension	yes	no
Allergies	yes	no	Hypotension	yes	no
Arthritis	yes	no	Hormonal Problems	yes	no
Artificial Joints	yes	no	Jaundice	yes	no
Asthma	yes	no	Kidney Disease	yes	no
Bruise Easily	yes	no	Liver Disease	yes	no
Cancer	yes	no	Lung Disease	yes	no
Codeine Allergy	yes	no	Night Sweats	yes	no
Diabetes	yes	no	Pacemaker	yes	no
Epilepsy	yes	no	Persistent Cough	yes	no
Genetic Problems	yes	no	Respiratory Problems	yes	no
Glaucoma	yes	no	Rheumatic Fever	yes	no
Heart Defects	yes	no	Sickle Cell Anemia	yes	no
Heart Disease	yes	no	Sinus Problems	yes	no
Heart Murmur	yes	no	Skin Disease	yes	no
Hepatitis	yes	no	Tuberculosis	yes	no

Dr. Paul M. Garcia, D.D.S., MAGD
3612 Edgewood Road
Columbus, GA 31907

HEALTH HISTORY NOTES

OFFICE USE ONY

Oral Health Risk Factors

Patients Name:_____

1. Do you smoke or have you EVER smoked? □ **Yes** □ **No**

(If no proceed to question 2)

The amount that you are presently smoking (Check all that apply)

__None (quit smoking completely) __Less than 1 pack of cigarettes per day __An occasional cigar
__An occasional cigarette __1-2 Packs of cigarettes per day __Cigars on a daily/regular basis
__A few cigarettes a day __2 or more packs of cigarettes per day __Occasional pipe smoker
__A pipe on a daily/regular basis

If you have quit smoking, when did you quit?

__Less than 6 months ago __6 months to a year ago __1 to 3 years ago __Over 3 years ago

How many years have you, or did you smoke?

__Less than two years __2-5 years __5-10 years __10-20 years __Over 20 years

2. Do you/ Have you EVER chew/ chewed tobacco or use/ used snuff or other similar substances? □**Yes** □**No**

(If no, proceed to question 3)

Are you STILL using smokeless tobacco or snuff? □**Yes** □**No**

If no, WHEN did you quit?

__Less than 6 months ago __6 months ago __1 to 3 years ago __Over 3 years ago

How many years did you use or have you used smokeless tobacco?

__Less than 1 year ago __1-2 years __2-5 years __Over 5 years ago

3. Approximate average amount of alcoholic beverages presently consumed per week:

__None __Less than 1 per week __1-5 drinks __6-11 drinks __11-20 drinks __Over 20 drinks

4. Do you have or have you ever had a substance abuse problem? □**Yes** □**No**

Describe_____

5. Do you presently use any recreational drugs? □**Yes** □**No**

List_____

6. Do you have or have you ever had an eating disorder? □**Yes** □**No**

If yes, please specify: _____

7. Do you have or have you ever had any head, neck or mouth piercing(s)? (Other than ears) □**Yes** □**No**

List_____

8. Do you have or have you ever been informed that you have been infected with an oncogenic strain (possible cancer causing) of the Human Papilloma Virus (HPV)? □**Yes** □**No**

9. Please list your family history or any family member's history of cancer:

_____

_____

10. Other concerns and considerations:

_____

_____

CONSENT – To the best of my knowledge, all of the above preceding information is correct and if there is ever any change in health, or medications, this practice will be informed of the changes without fail. I also consent to allow this practice to contact any healthcare provider(s) and to have the patient's health information released to aid in care and treatment. I also hereby consent to allow diagnosis, proper health care and treatment to be performed by this practice for the above named individual until further notice. I understand there are no guarantees or warranties in health or dental care.

Signature_____ Date_____

(Parent or guardian, if patient is a minor)

Reviewed By: _____

Dr. Paul M. Garcia, D.D.S., MAGD
3612 Edgewood Road
Columbus, GA 31907-2184

Medication	Start Date	End Date	Medical Problem	Action of Drug	Contra Indication	Drug Interactions	Physician & Phone #

In Case of Emergency:

Please give at least one name not living in your household.

Name_____ **Name**_____
Address_____ **Address**_____
City_____**State**_____ **City**_____**State**_____
Relationship_____ **Relationship**_____
Phone_____**Work**_____ **Phone**_____**Work**_____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor, and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. Dr. Garcia's office does not participate in any preferred provider plans nor does the practice absorb any remainder that the insurance company does not pay. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance at the time of service.

In order to control your cost of billings, we request that all charges not covered by your insurance carrier be paid at each visit.

If this account is assigned to an attorney or collection agency for collection and/or suit, the practice shall be entitled to reasonable attorney's fees and costs of collection.

I authorize the release of any information necessary to determining liability for payment and to obtain reimbursement on any claim.

I request that payment of authorization benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, private insurance, and other health plans to the practice of Paul M. Garcia, D.D.S.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

I agree to the assignments and financial responsibilities shown on this form.

You should read these terms carefully.

X_____ (L.S.) Date_____
Signed (Patient, or parent if under 18yrs. of age)

Dr. Paul M. Garcia, D.D.S., MAGD
3612 Edgewood Road
Columbus, GA 31907

DATE_____

I understand that I am responsible for the entire cost of any dental work performed by Dr. Garcia regardless of insurance coverage. I agree to pay the portion of my treatment not covered by insurance.

I realize that my insurance is filed as a courtesy to me by the staff of Dr. Paul M. Garcia and I agree to bring any check issued to me by the insurance company to go toward any balance I may have on account.

SIGNED _____

WITNESS _____

I, _____ give Dr. Paul M. Garcia permission to use my photographs for before and after examples so other patients can see the benefits of cosmetic dentistry.

SIGNED _____

WITNESS _____

Dr. Paul M. Garcia, D.D.S., MAGD
3612 Edgewood Road
Columbus, GA 31907

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but Acknowledgement could not be obtained because:

□ Individual refused to sign.

□ Communication barriers prohibited obtain the acknowledgement.

□ An emergency situation prevented us from obtaining acknowledgement.

□ Other (Please Specify)

_____

_____

_____